471-000-506 Nebraska Medicaid Practitioner Fee Schedule for Dental Services

Steps to Determine the Fee Schedule Allowable:

1. LOCATE THE PROCEDURE CODE. Procedure codes are listed numerically.

2. LOCATE THE MAXIMUM ALLOWABLE FEE FOR THE PROCEDURE CODE. The maximum allowable fee is listed to the right of the procedure code and description. If "BR" or “Fee Determined By Treatment Plan “ are listed, go to Step #4 for special pricing.

3. PAYMENT IS THE LOWER OF THE FEE SCHEDULE ALLOWABLE OR THE PROVIDER'S SUBMITTED CHARGE. The provider's submitted charge must reflect their change to the general public.

4. SPECIAL PRICING. Certain procedure codes will not have a maximum allowable fee:

   A. "BR" (By Report) - Paid at "reasonable charge" based on the service and circumstances. A complete description of the service (and additional documentation, if applicable) is required for review. The provider's submitted charge must reflect their charge to the general public.

   B. FEE DETERMINED BY TREATMENT PLAN – Paid at Medicaid prior authorized amount based on the services authorized. A complete description of the services/treatment to be provided is required for prior authorization review. The provider’s submitted charge on the prior authorization request must reflect their charge to the general public.

471-000-506 NEBRASKA MEDICAID DENTAL FEE SCHEDULE

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0120	periodic oral evaluation	17.00	No	Age 20 & Younger: Routine periodic oral evaluation are covered every 6 months Can be seen more frequently if determined necessary by treating dentist. Age 21 & Older: Routine periodic oral evaluation are covered 1 time every 12 months. Age 21 & Older with Special Needs: Routine periodic oral evaluation are covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition or a pregnant woman. Note – All Clients Oral evaluations are covered for new patients, emergency treatment, second opinions and specialists
D0140	limited oral evaluation – problem focused	16.00	No	
D0145	oral evaluation for a patient under 3 years of age & counseling with primary caregiver	28.00	No	
D0150	comprehensive oral evaluation – new or established patient	17.00	No	
D0160	detailed and extensive oral evaluation – problem focused, by report	27.00	No	
D0170	re-evaluation – limited, problem focused (established patient; not post-operative visit	16.00	No	
D0180	comprehensive periodontal evaluation – new or established patient	27.00	No	

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D0210	intraoral – complete series (including bitewings)	45.00	No	Maximum payment of $45.00 per date of service for any combination of codes D0210 – D0330.
D0220	intraoral – periapical first film	6.00	No	
D0230	intraoral – periapical each additional film	5.00	No	
D0240	intraoral – occlusal film (2 ¼ x 3 ¼ size)	7.00	No	
D0270	bitewing – single film	8.00	No	D0240 occlusal film is 2 ¼ x 3 ¼ size.
D0272	bitewings – two films	13.00	No	
D0273	bitewings – three films	15.00	No	Bitewings – maximum of 4 per date of service.
D0274	bitewings – four films	18.00	No	
D0330	panoramic film	34.00	No	Intraoral – complete series – covered every three years Panoramic film – covered every 3 years on a routine basis. Covered more frequently if necessary for treatment.
D0340	cephalometric film	62.00	No	Covered for clients age 20 and younger to diagnosis if treating dentist believes through visual exam that the client may qualify for Medicaid coverage of orthodontic treatment (see 471 NAC 6-005 page 11 of 14)
D0470	diagnostic casts	46.00	No	

PA* - Prior Authorization Required

PREVENTIVE

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D1110 D1120	prophylaxis – adult (age 14 and older) prophylaxis – child (age 13 and younger)	31.00 22.00	No No	Age 13 & Younger: Covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered the standard. BILL ON CODE D1120 Age 14 through Age 20: Covered at the frequency determined appropriate by the treating dentist with a 6-month prophylaxis considered the standard BILL ON CODE D1110. Age 21 & Older: Covered one time per year. BILL ON CODE D1110 Age 21 & Older with Special Needs: Covered at the frequency determined appropriate by the treating dentist. A client with special needs is a client who is unable to care for their mouth properly on their own because of a disabling condition or a pregnant woman.

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D1203	topical application of fluoride (prophylaxis not included) – child (age 13 and younger)	9.00	No	Covered at the frequency determined appropriate by the treating dentist.
D1204	topical application of fluoride (prophylaxis not included) – adult (age 14 and older)	9.00	No	Age 13 and younger bill on code D1203.
D1206	topical fluoride varnish; therapeutic-application for moderate to high caries risk patients	11.00	No	Age 14 and older bill on code D1204.
D1351	sealant – per tooth	23.00	No	Covered on permanent and primary teeth, children and adults. A re-seal is not covered more often than every 2 years.
D1510	space maintainer – fixed unilateral	110.00	No	Covered for clients age 20 and younger.
D1515	space maintainer – fixed – bilateral	190.00	No	
D1550	recementation of space maintainer	21.00	No	
D1555	removal of fixed space maintainer	21.00	No	

PA* - Prior Authorization Required

RESTORATIVE Operative dentistry fee includes local anesthetic, bases, or insulation and other procedures necessary to complete the case. Pins are billed separately. Maximum fee per tooth for any combination of amalgam or resin restoration procedure codes. The maximum fee is equal to the Medicaid fee for a 4 or more surface restoration.

Full labial veneers for cosmetic purposes are not covered. Documentation of carious lesions must be present.

Amalgam Restorations:

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2140	amalgam – one surface, primary	53.00	No	Primary teeth A – T
D2150	amalgam – two surfaces, primary	63.00	No	
D2160	amalgam – three surfaces, primary	75.00	No	
D2161	amalgam – four or more surfaces, primary	75.00	No	
D2140	amalgam – one surface, permanent	53.00	No	Permanent Teeth – 1 – 32
D2150	amalgam – two surfaces, permanent	63.00	No	
D2160	amalgam – three surfaces, permanent	75.00	No	
D2161	amalgam – four or more surfaces, permanent	86.00	No	
Resin-Based Composite Restorations:				
D2330	resin-based composite – one surface, anterior	62.00	No	Primary tooth numbers for anterior
D2331	resin-based composite – two surfaces, anterior	77.00	No	restorations – C – H, M – R
D2332	resin based composite – three surfaces, anterior	88.00	No	
D2335	resin based composite – four or more surfaces or involving incisal-angle (anterior)	103.00	No	Permanent tooth numbers for anterior restorations – 6 – 11, 22 - 27
D2391	resin-based composite – one surface posterior, permanent	63.00	No	Primary tooth numbers for posterior composite restorations – A, B, I, J, K, L, S, T
D2392	resin-based composite – two surfaces, posterior permanent	80.00	No	
D2393	resin-based composite – three surfaces, posterior, permanent	92.00	No	
D2394	resin-based composite – four or more surfaces, posterior, permanent	92.00	No	

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2391	resin-based composite – one surface posterior, permanent	63.00	No	Permanent tooth numbers for posterior composite restorations – 1 – 5, 12 – 16, 17 – 21, 28 - 32
D2392	resin-based composite – two surfaces, posterior, permanent	80.00	No	
D2393	resin-based composite – three surfaces, posterior permanent	92.00	No	
D2394	resin-based composite – four or more surfaces, posterior, permanent	103.00	No	
D2710	crown - resin – based composite (indirect)	205.00	Yes	Submit x-rays with prior authorization request
D2720	crown - resin with high noble metal	350.00	Yes	
D2721	crown – resin with predominantly base metal	350.00	Yes	
D2722	crown – resin with noble metal	350.00	Yes	Covered for anterior and bicuspid teeth when conventional restoration is not possible.
D2740	crown – porcelain/ceramic substrate	350.00	Yes	
D2750	crown – porcelain fused to high noble metal	350.00	Yes	
D2751	crown porcelain fused to predominantly base metal	350.00	Yes	
D2752	crown – porcelain fused to noble metal	350.00	Yes	Covered for molar teeth that have been endodontically treated that can not be adequately restored with a stainless steel crown, amalgam or resin restoration
D2790	crown – full cast high noble metal	350.00	Yes	
D2791	crown – full cast predominantly base metal	350.00	Yes	
D2792	crown – full cast noble metal	350.00	Yes	
Other Restorative Services:				
D2910	recement inlay, onlay, or partial coverage restoration	21.00	No	
D2915	recement cast or prefabricated post and core	40.00	No	
D2920	recement crown	21.00	No	
D2930	prefabricated stainless steel crown – primary tooth	123.00	No	
D2931	prefabricated stainless steel crown – permanent tooth	123.00	No	
D2932	prefabricated resin crown	110.00	No	Covered for primary anterior teeth
D2933	prefabricated stainless steel crown with resin window	142.00	No	
D2934	prefabricated esthetic coated stainless steel crown	142.00	No	Primary tooth
D2940	sedative filling	34.00	No	
D2950	core buildup, including any pins	78.00	No	
D2951	pin retention – per tooth, in addition to restoration	12.00	No	

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D2954	prefabricated post and core in addition to crown	100.00	No	
D2970	temporary crown (fractured tooth)	78.00	No	
D2980	crown repair, by report	BR	No	A description of treatment provided must be submitted on or in the dental claim. This service is reviewed prior to payment.
D2999	unspecified restorative procedure, by report	BR	No	
ENDODONTICS				
D3220	therapeutic pulpotomy (excluding final restoration)	70.00	No	Covered for primary teeth. Not covered for permanent teeth.
D3230	pulpal therapy (resorbable filling) – anterior primary tooth (excluding final restoration)	85.00	No	
D3240	pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	90.00	No	
D3310	root canal therapy – anterior (excluding final restoration)	234.00	Yes	Submit x-rays with prior authorization request.
D3320	root canal therapy – bicuspid (excluding final restoration)	266.00	Yes	Covered for permanent teeth.
D3330	root canal therapy – molar (excluding final restoration)	354.00	Yes	
D3346	retreatment of previous root canal therapy – anterior	234.00	Yes	Age 21 & older: Not covered for maxillary 2nd molar if 1st molar is in occlusion.
D3347	retreatment of previous root canal therapy – bicuspid	266.00	Yes	
D3348	retreatment of previous root canal therapy - molar	354.00	Yes	
D3351	apexification/recalcification	BR	Yes	Submit x-rays with prior authorization request.
D3410	apicoectomy	182.00	No	Covered on permanent anterior teeth.
D3999	unspecified endodontic procedure	42.00	No	Covered for emergency treatment to relieve endodontic pain. Include the tooth number on the claim.

PA* - Prior Authorization Required.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
PERIODONTICS				
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or bonded teeth spaces per quadrant	100.00	No	
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or bonded teeth spaces per quadrant	76.00	No	
D4341	periodontal scaling and root planning – four or more teeth per quadrant	100.00	Yes	Submit with PA request: 1. PA x-rays 2. Perio charting 3. Health history & medical information about the client 4 Information on how long a patient in dental office..
D4342	periodontal scaling and root planing – one to three teeth per quadrant	55.00	Yes	
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	60.00	No	Covered in addition to a prophylaxis procedure. (See page 4) Clients with special needs: Cover one-D4355, (maximum of 1) and one prophylaxis procedure per-quadrant (maximum of 4) for clients that have special needs. Special need clients are clients with mental retardation, or clients that must be treated in a hospital outpatient or Ambulatory Surgical Center setting.

PA* - Prior Authorization Required.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D4910	periodontal maintenance	31.00	Yes	Submit with PA request: 1. Date scaling & root planing completed. 2. Health history & medical information about the client. 3. Frequency client must be seen for maintenance procedure Covered for clients that have had periodontal scaling & root planing, and are compliant with home care within their abilities.

PA* - Prior Authorization Required.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
PROSTHODONTICS (REMOVABLE): A complete prosthetic appliance case includes all materials and necessary adjustments for a period of six months following placement of the prosthesis. Tissue conditioning is covered one time during the first six months following the placement of the prosthesis. (See D5850 and D5851.) Materials used for codes D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, D5820 and D5821 must be of a quality that with normal wear the prosthetic appliance will last a minimum of five years.				
D5110 D5120	complete denture – maxillary complete denture - mandibular	570.00 570.00	Yes Yes	Covered 6 months after placement of treatment/interim denture (D5810 and D5811) or as replacement of existing denture that is no longer wearable and can not be made wearable. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis. Submit with PA request: 1. Date of previous denture placement 2. Information on condition of existing denture.
D5130 D5140	immediate denture – maxillary immediate denture - mandibular	570.00 570.00	No No	Considered a permanent denture. Covered one time. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.

PA* - Prior Authorization Required.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
PARTIAL DENTURES: (Codes D5211, D5212, D5213, D5214) Covered if client does not have adequate occlusion. Adequate occlusion is defined as 1st molar to 1st molar, or a similar combination of anterior and posterior teeth on the upper or lower arch in occlusion. One to three missing anterior teeth should be replaced with a flipper partial (D5820 and D5821).				
D5211	maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	400.00	Yes	Submit with PA request: 1. Chart or list missing teeth. 2. Provide age of any existing partial and condition of that partial 3. X-rays of remaining teeth. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.
D5212	mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	400.00	Yes	
D5213	maxillary partial denture – case metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500.00	No	**Coverage limited to clients age 20 and younger.** Replaced one time if lost or broken. Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.
D5214	mandibular partial denture – case mental framework with resin denture bases (including any conventional clasps, rests and teeth)	500.00	No	
D5410	adjust complete denture – maxillary	21.00	No	Not covered for 6 months following placement of a new prosthesis. After 6 months covered as needed to make prosthetic appliance wearable
D5411	adjust complete denture – mandibular	21.00	No	
D5421	adjust partial denture – maxillary	21.00	No	
D5422	adjust partial denture – mandibular	21.00	No	
D5510	repair broken complete denture base	100.00	No	Covered as needed to make existing prosthetic appliance wearable.
D5520	replace missing or broken teeth – complete denture (each tooth)	***Note	No	
D5610	repair resin denture base	100.00	No	

PA* - Prior Authorization Required.
*** Note: First tooth $80.00, each additional tooth $30.00

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D5620	repair cast framework	115.00	No	Covered as needed to make existing
D5630	repair or replace broken clasp	115.00	No	prosthetic appliance wearable.
D5640	replace broken teeth – per tooth	***Note	No	
D5650	add tooth to existing partial denture	***Note	No	
D5660	add clasp to existing partial denture	110.00	No	
D5710	rebase complete maxillary denture	196.00	No	Not covered for 6 months following the
D5711	rebase complete mandibular denture	196.00	No	placement of a new prosthesis. After
D5720	rebase maxillary partial denture	196.00	No	6 months, covered as needed to make
D5721	rebase mandibular partial denture	196.00	No	existing prosthetic appliance wearable.
D5730	reline complete maxillary denture (chairside)	100.00	No	Not covered for 6 months following the
D5731	reline complete mandibular denture (chairside)	100.00	No	placement of a new prosthesis. After.
D5740	reline maxillary partial denture (chairside)	100.00	No	6 months, covered as needed to make
D5741	reline mandibular partial denture (chairside)	100.00	No	existing prosthetic appliance wearable.
D5750	reline complete maxillary denture (laboratory)	165.00	No	
D5751	reline complete mandibular denture (laboratory)	165.00	No	During the first 6 month period, following
D5760	reline maxillary partial denture (laboratory)	165.00	No	placement of a prosthetic appliance,
D5761	reline mandibular partial denture (laboratory)	165.00	No	tissue conditioning (D5850 & D5851) are covered. (See page 14 of 20).
D5810	Interim complete denture (maxillary)	370.00	No	Can be replaced with a complete
D5811	Interim complete denture (mandibular)	370.00	No	denture 6 months after placement of the interim denture. Complete dentures require prior authorization. (See page 11). Relines, rebases and adjustments are not covered for 6 months after placement of the prosthesis.

PA* - Prior Authorization Required.
*** Note: First tooth $80.00, each additional tooth $30.00

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D5820 D5821	interim partial denture (maxillary) (flipper partial) interim partial denture (mandibular) (flipper partial)	250.00 250.00	Yes Yes	Considered a permanent replacement for 1 to 3 missing anterior teeth. Not covered for temporary replacement of missing teeth Relines, rebases and adjustment are not covered for 6 months after placement of the prosthesis. Submit with PA request: 1. Chart or list missing teeth and teeth to be extracted. 2. Age of existing partials. 3. Information on condition of existing partial.
D5850 D5851	tissue conditioning, maxillary tissue conditioning, mandibular	46.00 46.00	No No	Covered one time during the first 6 months following placement of prosthesis. Covered at other times with documentation of medical necessity.
D6930	recement fixed partial denture	42.00	No	
ORAL AND MAXILLOFACIAL SURGERY				
D7111 D7140 D7210 D7220 D7230 D7240 D7241	extraction, coronal remnants – deciduous tooth (A – T) extraction, erupted tooth or exposed root (elevation and/or forceps removal) (A – T) (1 – 32) surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth. removal of impacted tooth – soft tissue removal of impacted tooth – partially bony removal of impacted tooth – completely bony removal of impacted tooth – completely bony, unusual surgical complications	44.00 56.00 93.00 122.00 167.00 202.00 212.00	No No No No No No No	Extractions are covered when there is documented medical need in the dental chart for the extraction. The Medicaid fee for extractions includes local anesthesia, suturing if needed, and routine postoperative care. (See 471 NAC 6-005, page 9 of 14)

PA* - Prior Authorization Required.

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D7250	surgical removal of residual tooth roots (cutting procedure)	88.00	No	(See coverage criteria on page 14 of 20)
D7270	tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	150.00	No	
D7280	surgical access of an unerupted tooth (permanent teeth only)	140.00	No	
D7282	mobilization of erupted or malpositioned tooth to aid eruption	114.00	No	
D7283	placement of device to facilitate eruption of impacted tooth (permanent teeth only)	135.00	No	
D7285	biopsy of oral tissue – hard (bone, tooth)	100.00	No	The Medicaid fee is for the professional component only. The lab must bill the specimen charge.
D7286	biopsy of oral tissue – soft	90.00	No	
D7310	alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces per quadrant	94.00	No	The Medicaid fee for extractions includes routine recontouring of the ridge and/or suturing as necessary. Alveoloplasty is a separate billable procedure. D7310 and D7311 are covered when it is necessary beyond routine recontouring to prepare the ridge for a prosthetic appliance.
D7311	alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	75.00	No	
D7320	alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces per quadrant	100.00	No	
D7321	alveoloplasty not in conjunction with extractions one to three teeth or tooth spaces, per quadrant –	81.00	No	
D7410	radical excision – lesion diameter up to 1.25 cm	BR	No	
D7411	excision of benign lesion greater than 1.25 cm	BR	No	
D7412	excision of benign lesion, complicated	BR	No	
D7413	excision of malignant lesion up to 1.25 cm	BR	No	
D7414	excision of malignant lesion, greater tan 1.25 cm	BR	No	
D7415	excision of malignant lesion, complicated	BR	No	

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D7440	excision of malignant tumor – lesion diameter up to 1.25 cm	BR	No	
D7441	excision of malignant tumor – lesion diameter greater than 1.25 cm	BR	No	
D7450	removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	BR	No	
D7451	removal of benign odontogenic cyst or tumor – lesion diam. greater than 1.25 cm	BR	No	
D7460	removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	BR	No	
D7461	removal of benign nonodontogenic cyst or tumor – lesion diam. greater than 1.25 cm	BR	No	
D7465	destruction of lesion(s) by physical or chemical method, by report	BR	No	
D7471	removal of lateral exostosis (maxilla or mandible)	110.00	No	
D7510	incision and drainage of abscess – intraoral soft tissue	42.00	No	
D7880	occlusal orthotic device, by report	BR	No	Occlusal orthotic devices are defined as splints that are provided for treatment of temporomandibular joint dysfunction. The fee includes any necessary adjustments. Document the type of appliance made and medical condition on or in the claim. For treatment of bruxism or for minor occlusal problems, see D9940. (See page 20 of 20).
D7960	frenulectomy (frenectomy or frenotomy) – separate procedure	98.00	No	

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
ORTHODONTICS: Orthodontic treatment is covered for clients age 20 and younger when determined to have a handicapping malocclusion by a Medicaid Dental Consultant. Orthodontic codes restricted to age 20 and younger are D8060 – D8999.				
D8060	interceptive orthodontic treatment of the transitional dentition Procedures covered under code D8060 · Chrome steel wire clasps-each .036 or minimum .030 · inclined plane (hawley) appliance, bite plane, with clasps · cross-bite appliance, anterior, acrylic · cross-bite appliance, posterior, two bands plus attachments · attachment springs for any orthodontic or pedodontic appliance - each · adjustment of pedodontic and interceptive orthodontic appliances (allowed one per month) · space maintainer – fixed – unilateral, part of interceptive orthodontic treatment plan · space maintainer – fixed – bilateral, part of interceptive orthodontic treatment plan	Fee determined by treatment plan 21.00 156.00 129.00 129.00 21.00 17.00 110.00 190.00	Yes Yes Yes Yes Yes Yes Yes Yes Yes	See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment.

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
D8090	comprehensive orthodontic treatment of the adult dentition	Fee determined by treatment plan	Yes	See 471 NAC 6-005 page 11 of 14 and page 12 of 14 for coverage criteria for orthodontic treatment.
	Procedures covered under code D8090:			
	· constructing and placing fixed maxillary appliance, active treatment	350.00	Yes	
	· constructing and placing fixed mandibular appliance, active treatment	350.00	Yes	
	· each one month period of active treatment – maxillary arch	35.00	Yes	
	· each one month period of active treatment – maxillary arch, unusual service (surgical correction case)	51.00	Yes	
	· each one month period of active treatment – mandibular arch	35.00	Yes	
	· each one month period of active treatment – mandibular arch, unusual service (surgical correction case)	51.00	Yes	
	· retainer or retention appliance	95.00	Yes	
	· each one-month period of retention appliance treatment, maxillary arch	19.00	Yes	
	· each one-month period of retention appliance treatment, mandibular arch	19.00	Yes	

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
	· rapid palatal expander (RPE) or cross-bite correcting (fixed) appliance	178.00	Yes	(Comprehensive orthodontic treatment continued.)
	· herbst appliance	270.00	Yes	
	· protraction facemask	162.00	Yes	
	· slow expansion appliance	177.00	Yes	
	· headgear	162.00	Yes	
	· inclined plane (hawley) appliance, bite plane, with clasps	156.00	Yes	
	· orthodontic appliance not listed	BR	Yes	
	· orthodontic procedure not listed	BR	Yes	
	· space maintainer – fixed – unilateral, part of comprehensive orthodontic treatment plan	110.00	Yes	
	· space maintainer – fixed – bilateral, part of comprehensive orthodontic treatment plan	190.00	Yes	
D8210	removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)	150.00	No	
D8220	fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	206.00	No	
D8691	repair of orthodontic appliance	BR	No	Include a description of the repair on or in the claim.
D8692	replacement of lost or broken retainer	95.00	No	Covered if the client is compliant with wearing the appliance.
D8999	unspecified orthodontic procedure, by report	BR	No	Billable for repairs associated with orthodontic treatment when repairs exceed routine repairs associated with orthodontic treatment. Include a description of the repair on or in the claim.

PA* - Prior Authorization Required

CODE	DESCRIPTION	FEE	PA*	COVERAGE CRITERIA/LIMITATIONS
ADJUNCTIVE GENERAL SERVICES:				
D9110	palliative (emergency) treatment of dental pain – minor Procedure	23.00	No	Examples: treatment of soft tissue infections, smoothing a fractured tooth. Include a description of the treatment on or in the claim.
D9220	general anesthesia – first 30 minutes	162.00	No	Covered when it is medically necessary to treat the client. Document the medical need in the dental chart.
D9221	general anesthesia – each additional 15 minutes	81.00	No	
D9230	analgesia, anxiolysis, inhalation of nitrous oxide	22.00	No	
D9241	intravenous conscious sedation/analgesia – first 30 minutes	94.00	No	
D9242	intravenous conscious sedation/analgesia - each additional 15 minutes	43.00	No	
D9248	non-intravenous conscious sedation	150.00	No	
D9410	house/extended care facility	35.00	No	Cover <u>one per day per facility</u> regardless of the number of patients seen. Document on or in the claim the name of the facility, or home address where treatment was provided.
D9420	hospital call	80.00	No	
D9440	office visit – after regularly scheduled hours	45.00	No	Covered in addition to exam and treatment provided when treatment is provided after dental office normal office hours.
D9940	occlusal guard, by report	173.00	No	Covered to minimize the effects of bruxism and other occlusal factors. Occlusal guards are defined as removable appliances. Document the medical need in the dental chart.

PA* - Prior Authorization Required